

		FOR OFF USE					

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**2004**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2004)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0034967</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Bethesda Lutheran Home-Plainfield</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>9/01/2003</u> to <u>8/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>805 Eastern Avenue</u> <u>Plainfield</u> <u>60544</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Will</u>		(Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>(815) 436-1901</u> <b>Fax #</b> <u>(815) 436-2247</u>		(Type or Print Name) <u>Kathleen Eulitz</u>	
<b>IDPA ID Number:</b> <u>39-0806446003</u>		(Title) <u>Regional Administrator</u>	
<b>Date of Initial License for Current Owners:</b> <u>4/24/1989</u>		(Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		(Print Name and Title) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) _____	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u>	
<input type="checkbox"/> Trust		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b>	
<b>IRS Exemption Code</b> <u>501(c)(3)</u>		<b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>	
<input type="checkbox"/> PROPRIETARY		<b>201 S. Grand Avenue East</b>	
<input type="checkbox"/> Individual		<b>Springfield, IL 62763-0001</b>	
<input type="checkbox"/> Partnership		<b>Phone # (217) 782-1630</b>	
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other			
<b>In the event there are further questions about this report, please contact</b> <b>Name:</b> <u>Karen S. Holton</u> <b>Telephone Number:</b> <u>(920) 206-4458</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Bethesda Lutheran Home-Plainfield# 0034967 Report Period Beginning: 9/01/2003 Ending: 8/31/2004

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,678</u>			<u>5,678</u>	13
14	TOTALS	<u>5,678</u>			<u>5,678</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 96.96%

D. How many bed-hold days during this year were paid by Public Aid?

178 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location

Date started 4/11/1989

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date Constructed 3/89 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: 8/31/2004 Fiscal Year: 8/31/2004

\* All facilities other than governmental must report on the accrual basis

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Bethesda Lutheran Home-Plainfield # 0034967 Report Period Beginning: 9/01/2003 Ending: 8/31/2004

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	23,501	695	1,157	25,353		25,353		25,353		1
2	Food Purchase		17,031		17,031		17,031		17,031		2
3	Housekeeping		3,381		3,381		3,381		3,381		3
4	Laundry		460		460		460		460		4
5	Heat and Other Utilities			12,547	12,547		12,547		12,547		5
6	Maintenance	2,008	2,027	4,939	8,974	46	9,020		9,020		6
7	Other (specify):* Waste Removal			1,736	1,736		1,736		1,736		7
8	<b>TOTAL General Services</b>	25,509	23,594	20,379	69,482	46	69,528		69,528		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	18,612	4,747	4,919	28,278		28,278		28,278		10
10a	Therapy	195,411			195,411		195,411		195,411		10a
11	Activities	42,545	1,845	511	44,901		44,901		44,901		11
12	Social Services										12
13	Nurse Aide Training										13
14	Program Transportation		4,124	3,231	7,355	334	7,689	(4,455)	3,234		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	256,568	10,716	12,861	280,145	334	280,479	(4,455)	276,024		16
	<b>C. General Administration</b>										
17	Administrative	53,386		24,509	77,895	(24,509)	53,386		53,386		17
18	Directors Fees										18
19	Professional Services					1,487	1,487		1,487		19
20	Dues, Fees, Subscriptions & Promotion			160	160	5,140	5,300		5,300		20
21	Clerical & General Office Expense	26,032	2,487	3,051	31,570	2,015	33,585		33,585		21
22	Employee Benefits & Payroll Tax			98,284	98,284	12,433	110,717		110,717		22
23	Inservice Training & Education					90	90		90		23
24	Travel and Seminar					310	310		310		24
25	Other Admin. Staff Transportation			437	437	453	890		890		25
26	Insurance-Prop.Liab.Malpractice			6,483	6,483	223	6,706	(1,500)	5,206		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	79,418	2,487	132,924	214,829	(2,358)	212,471	(1,500)	210,971		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	361,495	36,797	166,164	564,456	(1,978)	562,478	(5,955)	556,523		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number Bethesda Lutheran Home-Plainfield

#0034967

Report Period Beginning:

9/01/2003

Ending:

8/31/2004

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			24,587	24,587		24,587	(4,770)	19,817			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1,978	1,978		1,978			34
35	Rent-Equipment & Vehicle											35
36	Other (specify): <sup>a</sup>											36
37	<b>TOTAL Ownership</b>			24,587	24,587	1,978	26,565	(4,770)	21,795			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			42,779	42,779		42,779		42,779			42
43	Other (specify): <sup>a</sup>											43
44	<b>TOTAL Special Cost Centers</b>			42,779	42,779		42,779		42,779			44
45	<b>GRAND TOTAL COST</b>											
	(sum of lines 29, 37 & 44)	361,495	36,797	233,530	631,822		631,822	(10,725)	621,097			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

## STATE OF ILLINOIS

Page 5

Facility Name &amp; ID Number Bethesda Lutheran Home-Plainfield

# 0034967

Report Period Beginning:

9/01/2003

Ending:

8/31/2004

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotion				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (10,725)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (10,725)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport			\$		38
39						39
40	Gift and Coffee Shop					40
41	Barber and Beauty Shop					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

## STATE OF ILLINOIS

Page 5A

Bethesda Lutheran Home-Plainfield

ID# 0034967

Report Period Beginning: 9/01/2003

Ending: 8/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Related to Transporting Clients to/from workshop	\$ (4,455)	14	1
2	Related to Transporting Clients to/from workshop	(1,500)	26	2
3	Related to Transporting Clients to/from workshop	(4,770)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,725)		49

## Summary A

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

**Report Period Beginning:**

### Ending:

**8/31/2004**

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]





Facility Name &amp; ID Number Bethesda Lutheran Home-Plainfield

# 0034967

Report Period Beginning: 9/01/2003 Ending: 8/31/2004

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bethesda Lutheran Homes & Services, Inc	100%	Bethesda Lutheran Homes & Services, Inc	Watertown, WI			
		Bethesda Lutheran Homes & Services, Inc	Montgomery, IL			
		Bethesda Lutheran Homes & Services, Inc	Sycamore, IL			
		Bethesda Lutheran Homes & Services, Inc	Aurora, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17	Accounting Services	\$ 25,643	Bethesda Lutheran Homes & Services, Inc	100.00%	\$ 25,643	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 25,643			\$ 25,643	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Bethesda Lutheran Home-Plainfield # 0034967 Report Period Beginning: 9/01/2003 Ending: 8/31/2004

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Bethesda Lutheran Home-Plainfield # 0034967 Report Period Beginning: 9/01/2003 Ending: 3/31/2004

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Bethesda Lutheran Homes & Services, Inc  
 Street Address 600 Hoffmann Drive  
 City / State / Zip Code Watertown, WI 53094  
 Phone Number ( 920) 206-4458  
 Fax Number ( 920) 206-7711

B. Show the allocation of costs below. If necessary, please attach worksheets

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Accounting Services	Resident Days	307,898	\$ 1,348,276	\$ 966,918	5,856	\$ 25,643	1
2	17	Regional Office Allocation	Resident Days	56,422	388,361	222,106	5,856	40,308	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,736,637	\$ 1,189,024		\$ 65,951	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related							\$	\$			\$	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$	14
15	TOTALS (line 9+line14)							\$	\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ \_\_\_\_\_      Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Bethesda Lutheran Home-Plainfield**# **0034967** Report Period Beginning: **9/01/2003** Ending: **8/31/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	\$	1										
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2										
3. Under or (over) accrual (line 2 minus line 1).			\$	3										
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4										
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5										
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	7										
Real Estate Tax History:														
Real Estate Tax Bill for Calendar Year:	1999	8	<table border="1"> <tr> <td colspan="2"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2003 \$ 13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ 14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$ 15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION\$ 16</td> </tr> </table>		<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13	14	PLUS APPEAL COST FROM LINE 5 \$ 14	15	LESS REFUND FROM LINE 6 \$ 15	16	AMOUNT TO USE FOR RATE CALCULATION\$ 16
<b>FOR OHF USE ONLY</b>														
13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13													
14	PLUS APPEAL COST FROM LINE 5 \$ 14													
15	LESS REFUND FROM LINE 6 \$ 15													
16	AMOUNT TO USE FOR RATE CALCULATION\$ 16													
	2000	9												
	2001	10												
	2002	11												
	2003	12												

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Bethesda Lutheran Home-Plainfield    COUNTY    Will

FACILITY IDPH LICENSE NUMBER    0034967

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (    )    FAX #: (    )

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    YES    NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name &amp; ID Number Bethesda Lutheran Home-Plainfield

# 0034967

Report Period Beginning:

9/01/2003

Ending:

8/31/2004

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,400 B. General Construction Type: Exterior Vinyl Siding Frame Wood(with Sprinkler) Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization ☐ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

## XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Direct Care Building	90,915	1989	\$ 66,022	1
2	Land Improvements		1991-2004	9,873	2
3	TOTALS	90,915		\$ 75,895	3

Facility Name &amp; ID Number Bethesda Lutheran Home-Plainfield

# 0034967

Report Period Beginning:

9/01/2003

Ending:

8/31/2004

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16		1989	\$ 316,591	\$ 10,553	30	\$ 10,553	\$	\$ 163,571
5									
6									
7									
8									
Improvement Type**									
9	Carpeting	2000	4,230	141	30	141			564
10	Remodel Bathroom	2003	8,219	274	30	274			365
11	Replace Roof	2003	9,870	329	30	329			329
12	Remodel Kitchen-Cabinets	2003	10,000	305	30	305			305
13	Carpeting-Living Room	2003	1,663	50	30	50			50
14	Fire Door on Kitchen	2004	884	12	30	12			12
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$       351,457	\$       11,664		\$       11,664	\$	\$       165,196	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number: Bethesda Lutheran Home-Plainfield

# 0034967

Report Period Beginning:

9/01/2003

Ending:

8/31/2004

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 11,416	\$ 1,142	\$ 1,142	\$	10	\$ 7,541	71
72	Current Year Purchases	28,474	2,847	2,847		10	2,847	72
73	Fully Depreciated Assets	39,049					39,049	73
74								74
75	TOTALS	\$ 78,939	\$ 3,989	\$ 3,989	\$		\$ 49,437	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Clients	2001 Ford Windstar	2003	\$	\$ 2,026	\$ 2,026	\$	5	\$	76
77	Transport Clients	2004 Ford Freestar	2004	21,374	2,138	2,138		5	2,138	77
78										78
79										79
80	TOTALS			\$ 21,374	\$ 4,164	\$ 4,164	\$		\$ 2,138	80

## E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 527,665	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 19,817	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,817	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 216,771	85

\*\*

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2000 Chevy Van (Acquired 2000)	\$ 23,850	\$ 4,770	\$ 23,850	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 23,850	\$ 4,770	\$ 23,850	91

## G. Construction-in-Progres

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column f

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2005 \$ \_\_\_\_\_

13. \_\_\_\_\_/2006 \$ \_\_\_\_\_

14. \_\_\_\_\_/2007 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities:

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	<u>3</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	<u>3</u>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
- (c) For in-house training programs only. Do not include fringe benefit.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed  
 Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis  
 on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	1,126,516	1
2	Cash-Patient Deposits	300		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 40,000 )	103,092	5,320,764	3
4	Supply Inventory (priced at Cost )		396,866	4
5	Short-Term Investments		12,456,567	5
6	Prepaid Insurance		573,296	6
7	Other Prepaid Expenses		6,433,031	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest Receivable</u>		934,271	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 103,392	\$ 27,241,311	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		3,476,036	11
12	Long-Term Investments		115,090,801	12
13	Land	75,895	5,922,828	13
14	Buildings, at Historical Cost	351,457	70,419,527	14
15	Leasehold Improvements, at Historical Cost		385,303	15
16	Equipment, at Historical Cost	124,163	22,845,015	16
17	Accumulated Depreciation (book methods)	(240,621)	(44,966,000)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Construction-in-Progress</u>		3,650,939	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 310,894	\$ 176,824,449	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 414,286	\$ 204,065,760	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 11,480	\$ 1,442,959	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		1,678,912	30
31	Accrued Taxes Payable (excluding real estate taxes)		39,212	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Restricted Funds</u>		4,180,239	36
37	<u>Accrued Fringe Benefits</u>		1,857,509	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 11,480	\$ 9,198,831	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		671,971	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Minimum Pension Liability</u>		7,164,258	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 7,836,229	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 11,480	\$ 17,035,060	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 402,806	\$ 187,030,700	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 414,286	\$ 204,065,760	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 383,395</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 383,395</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>126,859</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 126,859</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Transfer Capital to Home Office</b>	<b>(107,448)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$ (107,448)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 402,806</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Bethesda Lutheran Home-Plainfield

# 0034967

Report Period Beginning: 9/01/2003

Ending: 8/31/2004

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses.**

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 756,192	1
2	Discounts and Allowances for all Levels	(10,250)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 745,942	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Cost of Transportation to/from Workshop	12,739	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 12,739	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 758,681	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	69,482	31
32	Health Care	280,145	32
33	General Administration	214,829	33
<b>B. Capital Expense</b>			
34	Ownership	24,587	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	42,779	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 631,822	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	126,859	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 126,859	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NA If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number **Bethesda Lutheran Home-Plainfield**

# 0034967

Report Period Beginning: 9/01/2003

Ending:

8/31/2004

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	441	491	9,355	19.05	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,810	3,085	42,545	13.79	9
10	Activity Assistants					10
11	Social Service Worker					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,764	2,069	23,501	11.36	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Worker	189	189	2,008	10.62	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	404	486	11,944	24.58	20
21	Assistant Administrator					21
22	Other Administrative	1,712	1,898	41,442	21.83	22
23	Office Manager					23
24	Clerical	1,897	2,123	26,032	12.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	428	482	9,257	19.21	29
30	Habilitation Aides (DD Homes)	15,780	17,104	195,411	11.42	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	25,425	27,927	\$ 361,495 *	\$ 12.94	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	25	\$ 1,157	1-3	35
36	Medical Director	12	4,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	360	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	49	\$ 5,717		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES								
<b>A. Administrative Salaries:</b>				<b>D. Employee Benefits and Payroll Taxes</b>			<b>F. Dues, Fees, Subscriptions and Promotions</b>	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lori Gilbert	Administrator		\$ 11,944	Workers' Compensation Insurance	\$ 14,306	IDPH License Fee	\$	
Regional Office Allocation	Administration		23,052	Unemployment Compensation Insurance	3,073	Advertising: Employee Recruitment		2,056
Home Office Allocation	Accounting Services		18,390	FICA Taxes	24,484	Health Care Worker Background Check		310
				Employee Health Insurance	32,101	(Indicate # of checks performed _____)		
				Employee Meals		Buyer's Club Membership		60
				Illinois Municipal Retirement Fund (IMRF)*		Plainfield Area Chamber of Commerce		100
				Pension	20,579	IARF		2,100
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Disability Insurance	2,784	Institute of Public Policy		649
(List each licensed administrator separately.)			\$ 53,386	Employee Physical Exam	172	Public Notary License		21
<b>B. Administrative - Other</b>				Other Miscellaneous	785	Newspaper Subscriptions		4
Description			Amount	Allocated Home Office Benefits	5,517	Less: Public Relations Expense	(	
Accounting Services-Home Office Allocation			\$ 7,253	Allocated Regional Office Benefits	6,916	Non-allowable advertising	(	
Administrative-Regional Office Allocation			17,256			Yellow page advertising	(	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 110,717	TOTAL (agree to Sch. V, line 20, col. 8)	\$	5,300
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 24,509	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
<b>C. Professional Services</b>				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	310
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$				TOTAL	\$ 310

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number Bethesda Lutheran Home-Plainfield

STATE OF ILLINOIS

# 0034967

Report Period Beginning: 9/01/2003

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Ending: 8/31/2004

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report Yes  
If YES, give association name and amount IARF- \$2,100
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 0 Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? YES X NO \_\_\_\_\_
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 42,779  
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? No If YES, attach an explanation of the allocation \_\_\_\_\_
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions \_\_\_\_\_
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation \_\_\_\_\_  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patient? 100%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? Yes  
Indicate the amount of income earned from providing such transportation during this reporting period \$ 12,739
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Virchow Krause & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? X If no, please explain \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees \_\_\_\_\_